STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E594	A. BUILDING 00 B. WING	06/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCGIVNEY HEALTH CARE CENTER	2907 E 136TH ST CARMEL, IN 46033

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F000000	This survey was for the Recertification and State Licensure Survey. Survey dates: June 8, 9, 10, 11, 12, and 13, 2014. Facility number: 000545 Provider number: 15E594 AIM number: N/A Survey team: Sandra Nolder, RN-Team Coordinator Janet Stanton, RN Michelle Hosteter, RN (June 9, 10, 11, 12, and 13, 2014) Gloria Bond, RN (June 9, 10, and 11, 2014) Census bed type: NF: 32 Total: 32 Census payor type: Medicaid: 31 Other: 1 Total: 32 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2. Quality Review was completed by Tammy Alley RN on June 19, 2014.	F000000	Disclaimer: Preparation, Submission, and Implementation of this Plan of Correction does not constitute an admission of/or agreement with the findings of this survey. McGivney Health Care Center reserves the right to contest the survey findings through the informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. The facility offers its responses, credible allegations of compliance, and plan of correction as part of ongoing efforts to provide quality of care. McGivney Health Care Center reserves the right to modify policies, procedures, and quality improvement systems as necessary to better meet the needs of the residents and facility.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F000282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on interview and record review, the facility was not following the care plan in regards to completing showers for 2 out of 7 residents reviewed for activities of daily living (ADL) . (Resident #7 and #23) Findings include: 1. On 6/13/2014 at 3:25 P.M., the record review was completed for Resident #23. Diagnoses included, but were not limited to, late effect stroke with neurological deficits, aphasia, tracheotomy, immunosuppresive disorder and depression. The resident was admitted 5/9/14. The MDS (Minimum Data Set) Assessment, dated 5/19/14, indicated the resident needed assistance of one person during a shower. The shower sheets indicated showers were given : 5/23-the resident was	F000282	1. Resident #7 and Resident #23 were given showers immediately upon recognition of issue. Director of Nursing contacted Resident #7 family to discuss concerns. Executive Director discussed with Resident #23 in regards to his wishes for daily showers. 2. All residents have potential to be affected by this deficient practice. 3. A laminated shower schedule will be placed in shower book and 24 hour report book for the nurses and CNA's to view. All direct care staff in-serviced on completion of shower sheets, shower policy, and appropriate documentation by 7/13/2014. Charge Nurse and/or Designee will assign CNA's resident rooms and showers. CNA's are responsible to fill out shower sheets completely and nurse will sign as completed, noting any areas of concern. Director of Nursing and/or Designee will obtain shower book and bring 5 times weekly to morning meeting to ensure compliance of showers for 30 days, then 3 times weekly	07/13/2014

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	documented to refuse the CNA and nurse in regards to a shower, 5/27, 6/3 indicated the resident refused, and that the shower was given on 2nd shift, 6/10 was shaved, and (shampoo) 6/12/14 the resident . There was no documentation the resident had been given a shower after admission on 5/9/14 through 5/23/14. There was no documentation that the resident had refused a shower during this time frame. In an interview on 6/9/2014 at 10:13 A.M., the resident indicated last time he had a shower or shaved was last Thursday. In an interview on 6/9/14 at 11:00 A.M., LPN #1 indicated the resident had received his showers on Tuesdays and Fridays on the first shift. LPN #1 provided a document titled "Shower schedule." The undated shower schedule indicated his shower days were Tuesdays and Fridays during day shift. She indicated first shift is 6 A.M. to 2 P.M. In an interview on 6/10/14 at 1:35 P.M., the resident indicated he had not gotten his shower that day. An observation of the resident's shower stall in his bathroom had several towels and a washcloth sitting in it.		for 90 days, and randomly thereafter. If found to be non-compliant, the specific staff member(s) will be re-inserviced and/or disciplined appropriately. 4. Findings will be brought to QAA for 6 months and then on a quarterly basis for 6 months or until deemed unnecessary by IDT team or Medical Director.5. DOC: 07/13/2014.	

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	On 6/11/14 at 10:45 A.M., CNA #3 indicated the resident was to have the shower usually right after breakfast. CNA #3 indicated if he doesn't have it first thing in the morning he will have behaviors and refuse, start throwing things, etc. The ADL care plan dated 6/11/14 indicated, "...Nurse Aide ...provide assistance with tasks as needed/requested,...." On 6/13/14 at 2:24 P.M., the DoN indicated the shower sheets were not being filled out as they should be, and that he had no documentation regarding showers for Resident #23 for 5/9 through 5/23/14. The DoN also indicated the resident was to be getting daily showers per the resident's choice. A document provided by the Director of Nursing (DoN) on 6/13/14 at 2:40 P.M., indicated the resident had been talked to by Social Services (SS) on 5/23/14. The document indicated, "...SS reported the resident aware of daily showers and shook head yes...." 2. During an interview on 6/10/14 at 6:05 P.M., a confidential family member indicated the resident had not been getting her showers on Wednesdays and			

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	Saturdays as scheduled. She indicated she had complained about the resident's showers to the previous Director of Nursing (DoN) to get them completed. She indicated after she complained about the showers the staff would do a good job for awhile then they "slacked" off until she complained again. She indicated the resident's hair and fingernails were dirty and she constantly complained about both of those also. Resident #7's record was reviewed on 6/11/14 at 2:11 P.M. Diagnoses included, but were not limited to, Alzheimers, legally blind and CVA with right sided hemiparesis. The Quarterly Minimum Data Assessment (MDS) dated 4/30/14, indicated the resident required total dependent assistance with two person physical assistance for bathing. The "CNA Assignment" sheet indicated the resident's shower days were on Wednesdays and Saturdays on the evening shift. The sheet indicated wash her hair often and she required total assistance. There was no documentation of showers being given on the following dates: 4/2/14, 4/5/14, 4/12/14, 4/16/14, 4/23/14,			

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	4/26/14, 4/30/14, 5/3/14, 5/10/14, 5/14/14, 5/17/14, 5/21/14, 5/28/14, 6/7/14. The resident had a Care Plan dated 4/29/14, that addressed the problem Self Care Deficit related to cerebrovascular accident, dementia and aphasia. The approaches included, but were not limited to: "10/4/13--Nurses..." "6/13/14--Nurse Aide--...Provide am and hs [bedtime] care...." During an interview on 6/12/14 at 2:30 P.M., the DoN indicated the CNA's were to document the resident's showers on the shower sheet or in the computer under "CNA Documentation." During an interview on 6/13/14 at 2:30 P.M., the ED indicated she did not have any further shower sheets for this resident to show she had received any further showers. 3.1-35(g)(2)			
F000312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.			

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	Based on observation, interview and record review, the facility failed to ensure showers were completed for 2 of 7 residents reviewed for Activities of Daily Living (ADL) care for showers. (Residents #7 and #23) Findings include: 1. During an interview on 6/10/14 at 6:05 P.M., a confidential family member indicated the resident had not been getting her showers on Wednesdays and Saturdays as scheduled. She indicated she had complained about the resident's showers to the previous DoN to get them completed. She indicated after she complained about the showers the staff would do a good job for awhile then they "slacked" off again until she complained again. She indicated the resident's hair and fingernails were dirty and she constantly complained about both of those also. Resident #7's record was reviewed on 6/11/14 at 2:11 P.M. Diagnoses included, but were not limited to, Alzheimers, legally blind, CVA with right sided hemiparesis and left hip nondisplaced impacted subcapital fracture left femur fracture. The Quarterly Minimum Data	F000312	1. Resident #7 and Resident #23 were given showers immediately upon recognition of issue. Director of Nursing contacted Resident #7 family to discuss concerns. Executive Director discussed with Resident #23 in regards to his wishes for daily showers. 2. All residents have potential to be affected by this deficient practice. 3. A laminated shower schedule will be placed in shower book and 24 hour report book for the nurses and CNA's to view. All direct care staff in-serviced on completion of shower sheets, shower policy, and appropriate documentation by 7/13/2014. Charge Nurse and/or Designee will assign CNA's resident rooms and showers. CNA's are responsible to fill out shower sheets completely and nurse will sign as completed, noting any areas of concern. Director of Nursing and/or Designee will obtain shower book and bring 5 times weekly to morning meeting to ensure compliance of showers for 30 days, then 3 times weekly for 90 days, and randomly thereafter. If found to be non-compliant, the specific staff member(s) will be re-inserviced and/or disciplined appropriately. 4. Findings will be brought to QAA for 6 months and then on a quarterly basis for 6 months or until deemed unnecessary by IDT team or Medical Director.5. DOC: 07/13/2014.	07/13/2014

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	Assessment (MDS) dated 4/30/14, indicated the resident required total dependent assistance with two person physical assistance for bathing. The "CNA Assignment" sheet indicated the resident's shower days were on Wednesdays and Saturdays on the evening shift. The sheet indicated to wash her hair often and she required total assistance. There was no documentation of showers being given on the following dates: 4/2/14, 4/5/14, 4/12/14, 4/16/14, 4/23/14, 4/26/14, 4/30/14, 5/3/14, 5/10/14, 5/14/14, 5/17/14, 5/21/14, 5/28/14, 6/7/14. During an interview on 6/11/14 at 2:40 P.M., LPN #1 indicated if the resident refused a shower, the CNA was to fill out the "Shower Report" and put refused on it. She indicated each day the resident was assigned a shower there should have been a shower sheet in the shower book for that resident to indicate if they had been offered a shower and refused or was given a shower. During an interview on 6/12/14 at 2:30 P.M., the DoN indicated the CNA's were to document the resident's showers on the shower sheet or in the computer under			

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	"CNA Documentation." During an interview on 6/12/14 at 3:15 P.M., CNA #2 indicated the resident received her shower last evening without any refusals and she had her hair washed. She indicated she was a two person assist transfer. During an interview on 6/12/13 at 3:15 P.M., CNA #3 and CNA #4 indicated the resident never refused her shower or any other care. CNA #3 indicated the only time the resident spit was if she had a bitter taste from her medicine in her mouth or she had some gristle from her food in her mouth. She indicated the resident did not like any kind of texture in her mouth and she would spit it out. She indicated she was not spitting during her showers because she was having a behavior. During an interview on 6/13/14 at 2:30 P.M., the ED indicated she did not have any further shower sheets for this resident to indicate she had received any further showers.			
F000329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive			

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	dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on interview and record review, the facility failed to identify and quantitatively monitor specific behaviors to support the use of psychotropic medications, and failed to provide an appropriate diagnosis for a psychotropic medication prior to it's use; for 6 of 6 residents reviewed for Unnecessary Medications who were receiving anti-psychotic, anti-depressant, or hypnotic medications. (Residents #3, #5, #23, #24, #25, and #29) Findings include: 1. The clinical record for Resident #5 was reviewed on 6/13/14 at 10:45 A.M. Diagnoses included, but were not limited	F000329	1. Resident #3, #5, #24, #25, and #29 behavior monitoring sheets and care plans were reviewed and updated with assistance of Lacey Beyl & Company Consultant. Resident #23: upon return to facility from hospitalization the antipsychotic medication was discontinued from use. 2. All residents have potential to be affected by this deficient practice.3. All residents identified above were reviewed by the Medical Director and dose reductions were ordered as deemed necessary by physician. Facility staff members will be in-serviced on the facility-wide behavior monitoring program by 07/13/14. Nursing staff will be in-serviced on appropriate documentation to	07/13/2014

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	to, diabetes Type II, dementia with behavior disturbance, bipolar with current depressive phase, history of alcohol abuse, gout, and chronic pain. The Level II PASRR (Pre-Admission Screening and Resident Review), dated 3/7/14, indicated the resident was receiving medications which included Cymbalta (an anti-depressant), Ativan (an anti-anxiety), and Seroquel (an anti-psychotic) for diagnoses of dementia with depression and behavioral features, and bipolar with psychotic features. A further description of how the psychotic features were displayed was not given. The Consultant Psychiatrist progress notes, on 3/14, 5/14, and 6/3/14, indicated the resident had dementia with depression, bipolar disorder, and delusions. The reports indicated all behaviors were stable. Further descriptions of how the bipolar and delusional behaviors were displayed were not given. The May, 2014 Physician Order recap (recapitulation) list included the following medications with the date ordered: 2/14/14--Duloxetine (Cymbalta) 30 mg. (milligrams)--Take 3 capsules by mouth once daily, for pain management.		support the use of psychotropic medications by 07/13/2014. All staff members will use Behavior Monitoring Sheets to document any observed behaviors. DON/Designee will bring behavior monitoring book to the behavior meetings daily X5; all behaviors will be reviewed by IDT Team. IDT team member will record behaviors on the behavior/intervention monthly flow records. These results will be charted by exception, i.e. charting will reflect data only when the identified behavior occurs. Nurse's notes will be reviewed by the IDT team on a routine basis and during daily behavior meetings to ensure accurate documentation supported by behavior monitoring sheets and ensure that appropriate interventions were implemented and documented. Care plans will be updated on an as needed basis to reflect appropriate interventions. DON/Designee and MDS Coordinator will review and update 4 resident charts per week until all residents care plans have been addressed with assistance of Lacey Beyl & Company Consultant until Social Service Director position is filled. 4. Findings to QAA on monthly basis as this is an on-going program.5. DOC: 07/13/2014.	

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	10/16/13--Lorazepam (Ativan) 0.5 mg.--take 1/2 tablet (0.25 mg.) by mouth twice daily. 2/24/14--Quetiapine (Seroquel) 100 mg.--take one tablet by mouth twice a day. On 5/19/14, the physician decreased the dosage of the Ativan from 0.25 mg. twice a day to 0.25 mg. daily. The "Behavior/Intervention Monthly Flow Record" sheets for Resident #5 indicated the following: April, 2014--One form indicated the monitoring was for the Cymbalta anti-depressant medication. Behavior #1 was listed as "Yelling/Cursing," and Behavior #2 was listed as "Refuses Care." The second form indicated the monitoring was for Seroquel anti-psychotic medication. Only one targeted behavior was listed for monitoring: "Socially inappropriate toward others." May, 2014--One form indicated the monitoring was for the Lorazepam (Ativan) anti-anxiety medication. Targeted behaviors for monitoring were listed as "Yelling/cursing," and "Refuses care." A second form indicated the monitoring was for a medication being given for pain (Gabapentin--Neurontin).			

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	There were no forms to quantitatively monitor behaviors to support the use of the Seroquel or Cymbalta. There was one "white" behavior sheet, with one entry dated 5/27/14. The entry indicated "Pt. [patient] cursing at staff when entering dining room as children choir was singing/taking place. Pt. was given potato chip. Pt. redirected to go out of dining room. Pt. threw potato chips bag on the wall. Pt. calm down and went back to room." June, 2014--One form indicated the monitoring was for the Lorazepam and Cymbalta. The targeted behaviors were listed as "Yelling/cursing," and "Refusal of care." A second form indicated the monitoring was for the Seroquel. The targeted behavior was listed as "Sexually inappropriate." There was one "white" form which was blank. Nurses' progress notes from 6/1/13 to 6/13/14 had documentation of infrequent refusal of care and yelling/cursing. There was no documentation related to any psychotic or psychotic-type behaviors or delusions. Social Service progress notes, from 4/14/14 through 5/20/14, did not identify or address any behaviors that would support the use of the medications.			

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	2. The clinical record for Resident #25 was reviewed on 6/11/14 at 12:44 P.M. Diagnoses included, but were not limited to, chronic pain syndrome, dementia with behavior disturbance, depression, paranoia, delusions, insomnia, and anxiety. A Level II PASRR (Pre-Admission Screening and Resident Review), dated 7/20/12, indicated the resident's medications at that time included Seroquel (an anti-psychotic), Trazadone (an anti-depressant), and Effexor (an anti-depressant). Diagnoses were listed as chronic pain, anxiety, paranoia, and adjustment disorder. The form indicated "Referred for Level II due to reported statement of suicidal ideation. Staff report resident is generally in anxious mood, reported behaviors of yelling out for help today, though this is said to be unusual for her." A Level II PASRR, dated 2/27/14, indicated the resident's current psychotropic medications were Effexor, Seroquel, Desyrel (Trazadone). Psychiatric diagnoses were listed as "Dementia." The form indicated "This Individual IS NOT mentally ill." The form had been completed by the previous Social Service Director, who was			

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	terminated from the facility on 6/6/14. A Consultant Psychiatrist evaluation, dated 2/7/14, indicated "Evaluated for history of dementia, delusions, depression. Moods, behaviors stable now." A subsequent evaluation, dated 4/3/14, indicated "Rule out Signs/Symptoms of depression: 'i'm sad because I'm in pain." Apathetic attitude, withdrawn behavior, blunted affect, depressed mood, concrete thought processes, impaired judgment, impaired insight. Not appropriate for individual therapy at this time; involve in milieu as much as possible; evaluate pain management regimen." The June 2014 Physician Order recapitulation form included the following medications with the date ordered: 2/24/14--Venlafaxine (Effexor) XR 75 mg. (milligrams), take one capsule by mouth once daily. 5/19/14--Quetiapine (Seroquel) 25 mg.--Take 1/2 tablet (12.5 mg.) by mouth daily at bedtime. 4/14/14--Trazadone 50 mg.--take one tablet by mouth once daily at bedtime. The "Behavior/Intervention Monthly Flow Record" forms for Resident #25 indicated the following:			

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	December, 2013--One form listed all of the psychotropic medications, and also included a medication prescribed for pain (Gabapentin--Neurontin). There was one targeted behavior for monitoring--"(History of) Yelling." January, 2014--The form was the same as for December. The targeted behavior was "Yelling (history of)." No forms for February, March, or April were provided for review. May, 2014--The medications listed for monitoring were Trazadone and Effexor. The targeted behavior was listed as "History of yelling out." There was no monitoring form for the Seroquel. There were no "white" behavior forms. June, 2014--All psychotropic medications were listed for monitoring, as well as a medication for pain (Gabapentin--Neurontin). The targeted behavior was listed as "History of yelling out." There was no indication that the resident was being monitored for depression, delusions, paranoia, or paranoid-type behaviors. There were two Social Service progress			

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	notes that documented the following: 4/15/14--"Attempted to speak with resident this morning and resident stated "I don't feel like talking today." Appeared to be in a good mood, resident was lying down in bed and appeared to be getting ready to nap." 5/20/14--"Attempted to meet with resident twice in afternoon with no success. Was sleeping both times." 3. The clinical record for Resident #29 was reviewed on 6/12/14 at 1:19 P.M. Diagnoses included, but were not limited to, Parkinson's disease, dementia with behavior disturbance, and depressive disorder. A PASRR/MI Mental Health Assessment (Pre-Admission Screening and Resident Review/Mental Illness), dated 9/14/12, indicated the following: "Has been living in AL [Assisted Living] in Indy since 5/6/12. Prior to that had been with various family members. States she would prefer to live alone, in her own home, however, this is no longer feasible due to pt's [patient's] current level of moderate dementia, limited safety awareness, persistent delusions, and actively exit-seeking behaviors. Maintains regular contact with her [family members] who all live within the Indy area. Pt.'s [name of family member]			

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	has POA [Power of Attorney] and assists with HC [Health Care] and financial decision-making. Admitted to hospital due to increased delusions, paranoid thoughts, verbalized suicide ideation without a plan, verbalized homicidal ideation (with stated plans to either shoot [another known person] or to hire someone to kill [a family member], refusal of psych medications, and verbal and physical aggression toward staff and others at AL." A Consultant Psychiatrist initial assessment report, dated 4/17/14, indicated the resident had a diagnosis of senile dementia--Alzheimer's type and late onset, and depressed mood. The report indicated the resident was a little anxious, confused, and not oriented. She "appears stable with mental health. She has some confusion, but does not seem distressed." Consultant Psychiatrist's progress notes, dated 5/19 and 6/5/14, indicated the resident "dementia, delusions, depression, mood, behavior stable," and to "continue meds [medications], support, redirect, and encourage ADLs [Activity of Daily Living." The June 2014 Physician Order recapitulation sheet included the			

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	following medications and order dates: 12/3/13--Haloperidal (Haldol) 2 mg./ml (milligrams/milliliters)--give 1 ml. (2 mg.) by mouth once daily. 2/18/14--Olanzapine (Zyprexa) 5 mg. one tablet by mouth once daily in the morning (8 A); Olanzapine (Zyprexa) 2.5 mg. one by mouth twice daily at 12 PM and 8 PM. 5/6/14--Sertraline (Zoloft) 25 mg. one tablet by mouth once daily at bedtime. The "Behavior/Intervention Monthly Flow Record" sheets for Resident #29 indicated the following: April, 2014--The medication listed for monitoring was Olanzapine (Zyprexa). The targeted behaviors were listed as "Yelling/Cursing," and "Physical Aggression." May, 2014--There were two forms. The medication listed on the first form for monitoring was Olanzapine (Zyprexa). The targeted behaviors were listed as "Yelling/Cursing," and "Physical Aggression." A second form had the Sertraline (Zoloft) anti-depressant medication listed for monitoring. There were no target behaviors listed. June, 2014--The medication listed for monitoring was Olanzapine (Zyprexa). The targeted behaviors were listed as			

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	"Yelling/Cursing," and "Physical Aggression." There was no behavior monitoring for specific targeted behaviors to support the use of Haldol. There was no specific targeted behaviors to support the use of the Zyprexa. 4. The clinical record for Resident #24 was reviewed on 6/11/14 at 3:45 P.M. Diagnoses included, but were not limited to, vascular dementia without behavior disturbance, paranoid state, history of CVA (cerebral vascular accident--stroke), and seizure disorder. A physician progress note, dated 5/19/14, indicated the resident had failed a reduction in the dosage of Olanzapine (Zyprexa) anti-psychotic medication. There was no other information related to the date the reduction was attempted, or what occurred in the way of increase psychotic or paranoid type behaviors. A Consultant Psychiatrist progress note, dated 6/5/14, indicated the resident had diagnoses of dementia and delusions, with mood and behaviors stable. The May, 2014 Physician Order recapitulation sheet included the following medications and order dates:			

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	10/8/13--Lorazepam (Ativan) Intensol 2 mg./ml. (milligrams/milliliter)--give 0.25 ml. (0.5 mg.) po three times a day. 5/19/14--Olanzapine (Zyprexa Zydis) 10 mg. po daily at 4 P.M. 5/19/14--Olanzapine (Zyprexa Zydis) 5 mg. po daily at 4 PM. The "Behavior/Intervention Monthly Flow Record" sheets for Resident #24 indicated the following: May, 2014--There were two forms. The first form listed the Lorazepam (Ativan) anti-anxiety medication for monitoring. The targeted behavior for monitoring was "History of exit-seeking." The second form listed the Olanzapine (Zyprexa) anti-psychotic medication for monitoring. There was no target behavior to support the use of the anti-psychotic medication listed. June, 2014--The medications of Zyprexa and Ativan were listed on one form for behavior monitoring. The targeted behavior was listed as "History of exit-seeking." There was no specific targeted behaviors to support the use of the Zyprexa or Ativan. Only one Social Service progress note			

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	was located. The note, dated 4/22/14, indicated the Social Service Director "Spoke with resident in regards to how resident was doing...." There was no documentation related to behavior diagnoses, issues, or psychotropic medications. 5. Resident #3's record was reviewed on 6/11/14 at 2:00 P.M. Diagnoses included, but were not limited to dementia with behavior disturbances, schizoaffective disorder, dementia with behavior disturbances, anxiety disorder, and depressive disorder. A Psychotherapy progress note dated 2/25/14, indicated "...Concerns Noted by Staff...labile mood, isolation in Room, Attention Seeking...." A Psychotherapy progress note dated 3/10/14, indicated "...Concerns Noted by Staff...Sadness, tearful, irritable, Attention seeking...." A Psychotherapy progress note dated 4/17/14, indicated "...Concerns Noted by Staff... Pt was very tearful...She was agitated and had trouble focusing...." A Physician progress note dated 5/14/14, indicated "...Dementia, Alzheimer w [sign for with] Delusions, Dementia, Alzheimer w Depression... Increase			

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	Cymbalta 90 mg [milligrams] continue meds...." A Physician progress note dated 6/9/14, indicated "Chief Complaint: Involved in Res [resident] to Res Altercation... Continue Present Treatment Plan: No Plan: Psych [Psychiatric] Hospitalization...." A June 2014 recap (Recapitulation) included, but were not limited to, the following Physician orders: 11/08/13-Invega Sustenna (An anti-psychotic medication) 234 mg (milligrams) Inject contents of 1 syringe Intramuscularly once monthly for Schizoaffective disorder. 11/08/13-Clonazepam (An anti-anxiety medication) 0.5 mg by mouth twice daily for anxiety disorder 11/08/13-Risperidone (An anti-psychotic medication) 0.5 mg by mouth twice daily for Schizoaffective disorder 11/08/13-Trazodone (An anti-depressant medication) 50 mg by mouth daily at bedtime for depressive disorder 11/27/13-Divalproex Sodium Extended Release (A mood stabilizer medication)500 mg by mouth Take 3 tablets (1500 mg) by mouth at bedtime A Physician order dated 5/15/14, indicated the resident's Cymbalta			

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	(Duloxetine HCL) (An anti-depressant medication) was to be increased to 90 mg daily. The "Behavior/Intervention Monthly Flow Record" sheets for Resident #3 indicated the following: June, 2014--The medications of Depakote, Duloxetine HCL, Risperidol, Trazodone, Invega, and Clonazepam were all on one form for behavior monitoring. The targeted behaviors for all these medications was listed as "Crying / tearfulness." No further "Behavior/Intervention Monthly Flow Record" forms were provided for review. The "Behavior/Intervention Monthly Flow Record" had the following documentation of behaviors on the following dates: Day Shift--No documentation of any behaviors. Evening Shift--1 documented behavior of yelling and crying on 6/11/14. Night Shift--No documentation of any behaviors. There was no indication that the resident was being monitored for depression, delusions, paranoia, or paranoid-type			

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	behaviors. The nurses's progress notes dated from 11/11/13 to 6/12/14 had documentation of frequent episodes of tearfulness and crying, infrequent refusals of care and meals. She would infrequently make false statements about the staff. She would infrequently curse the staff and as she walked down the hallway to and from her room and slam her door. She frequently yelled loudly and screamed in her room, in the hallway and at the nurses station. There was no documentation related to psychotic or psychotic-type behaviors, hallucinations or delusions. During an interview on 6/8/14 at 6:55 P.M., CNA # 6 indicated Resident #3 slammed her door to her room, yelled and cursed at the staff all the time. During an interview on 6/12/14 at 11:30 A.M., the Executive Director indicated the behaviors being monitored for this resident's psychotropic medications were crying and tearfulness. She indicated there were not any specific targeted behaviors being monitored for this resident's psychotropic medications. 6. On 6/13/2014 at 3:25 P.M. the record review was completed for Resident #23. Diagnoses included, but were not limited to, late effect stroke with neurological			

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	deficits, aphasia, tracheotomy, immunosuppresive disorder and depression. The PASSR (Pre-Admission Screening and Resident Review) dated 3/17/14 indicated the resident was not mentally ill. The initial psych evaluation dated 5/13/14 for Resident #23, indicated the resident had a diagnosis of vascular dementia. A document titled, "Behavior Monitoring Documentation" indicated the following: "5/12/13 7:45 P.M. the resident went to nursing station to fix his trach collar, after nurse asked if it was ok he went to the door of facility and attempted to open the door. The resident after being told it had a code, wheeled wheelchair to the nurses station and knocked the mouse from the computer off of the desk and then returned self to room. Then he picked up the ice pitcher and knocked it on the floor... 5/13/14 3:00 A.M. Resident up throwing stuff on ground,. Resident agitated (reason unknown) resident was toileted x 3 this shift. Resident gets upset when you don't do something right away...6 A.M. Resident up all night back and			

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	forth to bathroom, threw breathing treatment machine on the floor... 5/19/14 10 P.M. Patient upset because wanted the toilet seat to be cleaned after he used it. Patient informed toilet seat was cleaned with sani cloth and cleaned the best way possible and patient slamming the door after the staff left the bedroom... 5/28/14 11:30 A.M. Patient upset because he had knocked over trash in the main dining room and was hard to understand, resident began to attempt to hit staff, removed his trach cannula and threw it, writer asked 'why are you doing this?' Resident didn't answer, just steamed to room and slammed the door... 6/8/14 7:05 P.M. Resident in hall taunting other female resident asked resident to move over so she could pass. As female resident passed resident smacked her in the arm the other female resident then turned and smacked resident's shoulder. No injuries noted to either resident ... 6/9/14 4:30 P.M. Patient upset unable to get in touch with brother. Managed to squeeze through his wheelchair in the hallway and hit the nurses back of leg. Patient went to his room and slammed the door. 5 P.M. Patient got upset when papers were given to him for writing letters. Patient threw papers on the floor. Patient went to bed and pulled the			

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	privacy curtain...." A document titled "Behavior and Mood Record", indicated the following: "...5/22/214 5:44 P.M. patient upset when told that his shower days are on Tuesday and Friday. Patient states 'that's wrong'. Patient then sat the dining room and refusing all PM meds and vital signs to be taken. Patient teaching and reassurance given but patient still refused... 5/23/14 7:42 P.M. Resident anxious over shower. Went to the dining room and continue speaking about shower. Another resident stated,'you have been told x 3 when shower will be given.' Resident pushed the table. Other resident became agitated and stated, 'if you want to hit me, come on over.' Resident smacked the other resident's arm... 5/29/14 5:35 P.M. Resident was noted to be agitated regarding staff asking if he would like to apply sun block prior to sitting outside. Resident became agitated and knocked over trash container in dining room. Resident also removed his lary tube (a tube used in the tracheal tube of resident with tracheotomy) and threw it on the floor...." The Behavior/Intervention Monthly Flow Record indicated in May 2014 he had two episodes of physical aggression towards			

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	staff and residents. The intervention codes indicated on 5/19/14 the staff had redirected the resident, given him 1 on 1 time, and toileted him with a positive outcome. 5/23/14 the staff had the staff had redirected the resident, given him 1 on 1 and resident returned to room with a positive outcome. The Behavior/Intervention Monthly Flow record for June 2014 indicated he had four episodes of agitation and no episodes of throwing his lary tube. The June record had "Zyprexa (an anti-psychotic medication) 5 milligrams 6/11/14" hand written at the bottom. On 6/9/14 at 11;30 A.M., LPN #1 was overheard in a conversation with the attending physician. The nurse described the resident-to-resident slapping incident as "inappropriate touching." She received an order from the physician for Zyprexa, an anti-psychotic medication. In an interview following the phone call, the LPN indicated the resident had never had this type of behavior before, so she called the doctor. On 6/12/14 at 9:30 A.M., the Executive Director was requested to provide the facility's Behavior Management program, protocol, or policy/procedure. In an interview on 6/12/14 at 11:15 A.M., the			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Executive Director and MDS Coordinator indicated the facility's Behavior Management program was overseen by the Social Service Director. They described the process as follows: Each day after his arrival, the Social Service Director would review the Behavior Log book. He would look at the "Behavior/Intervention Monthly Flow Record" and the "white" behavior sheets for any entries on behaviors since the previous day, and review the chart for any Nurses progress notes related to behavior. In the subsequent morning meeting, he would summarize the information for the other team members. Following the meeting, he would would type the summary of meeting in his computer. In his absence, other administrative staff on QA (Quality Assurance) committee would do the review. The QA committee also reviewed Unnecessary Medications in QA meetings. No information was provided related to how the facility determined what type of behavior required monitoring in order to support the use of an anti-psychotic, anti-anxiety, or anti-depressant medications. In the interview, the Executive Director indicated the Social Service Director had			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E594	A. BUILDING 00 B. WING	06/13/2014

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	been terminated the previous week, and not available for interview. 3.1-48 (a)(3) 3.1-48(a)(4)			
F000458 SS=D	483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms. Based on observation, interview and record review, the facility failed to ensure a resident bedroom measured at least 80 square feet per resident room for 1 of 18 rooms. The deficient practice had the potential to affect 2 of 2 residents who resided in this room. (Room #1) Findings include: During an interview during the entrance conference on 6/8/14 at 7:35 P.M., the Executive Director indicated no physical changes had occurred for any of the 2 resident rooms previously waivered for room size since the last survey on 6/19/13 (Rooms #1 and # 5). She indicated room number 5 only had 2 beds	F000458	McGivney Healthcare is requesting a waiver for room 1. This room is located in the oldsection of our building and historically, ISDH has granted room size waiver. This room meets the needs of the two (2) residents and does not create a hazard to their safety. Letter mailed to Director of ISDH 06/26/2014. See attachment	07/13/2014

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	instead of 3 beds. Room number 5 was measured at 229.75 sq. ft. The room had two beds and each side of the room measured 114.88 sq. ft. per resident. The "Bed Inventory" form, completed by the Executive Director (ED) dated 6/8/14, indicated room number 1 was a Title 19 NF (Medicaid) room, and was certified for 2 resident beds. During the entrance tour on 6/8/14 at 6:35 P.M., it was observed two residents were occupying room number one. Review of facility measurements for resident room number 1 indicated the bedroom lacked 80 sq. ft. per resident as follows: *1-2, 149.67 sq. ft., 74.83 sq. ft. During an interview on 6/13/14 at 10:15 A.M., the Executive Director indicated she had contacted the State Agency regarding the previous room waiver and the only room that needed to have a room waiver was room number 1. 3.1-19(l)(2)(A)			

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